File No. REG-2007-00005 **May 15, 2007**

CALIFORNIA CODE OF REGULATIONS, TITLE 10.
CHAPTER 5, SUBCHAPTER 2

AMEND ARTICLE 1.3 TO READ:

ARTICLE 1.3 **REVISED MANDATED BENEFITS** A**NALYSIS REGULATIONS**

Section 2218.60 Definitions

(a) The term "health insurer" means any disability insurer that issues a policy of "health insurance" as defined in California Insurance Code Section 106.

(b) The term "number of covered lives" means the sum of all named insured and all covered dependents insured by a health insurer.

(c) The term "percent to total ratio" means the total number of covered lives insured by a health insurer in the state of California divided by the total number of covered lives insured by all health insurers in the state of California.

d) The term "total need" means the dollar amount the Department of Insurance has determined that it is responsible for and has stipulated in order to fund the University of California study of mandated benefits required by California Health and Safety Code Section 127760. The dollar amount of the "total need" shall be calculated in the manner described in 2218.61(b).

Authority cited: California Health & Safety Code Section 127662 California Insurance Code Sections 12921 and 12926.
Reference: California Insurance Code 127660, 127661, 127662,

Section 2218.61 Assessment of Fee

(a) Each health insurer shall be assessed, and shall pay, a fee in an amount determined by the formula set forth in Section 2218.62 for each policy written in California for insurance or group disability insurance that provides coverage for hospital,

medical, or surgical benefits; however, health insurance described in Health & Safety Code Section 127662(c)(4) shall not be subject to any assessment by the Commissioner.

(b) The dollar amount of total need shall be determined by the Department of Insurance and the Department of Managed Care in consultation with the University of California and shall be limited to the amount necessary to fund the actual and necessary expenses of the university and its work in implementing Health and Safety Code Section 127660. The total amount of assessment on health insurers and health care service plans when combined together shall not exceed two million dollars ($2,000,000.00) annually. The total annual assessment of health insurers shall not exceed 12.4% of the total annual assessment of health insurers and health care services plans combined.

(c) The Commissioner shall calculate and levy an assessment of all health insurers equal to the appropriation contained in the State Budget for the administrative and operational costs arising from the provisions of Chapter 7 (commencing with Section 127660), Part 2 of Division 107 of the Health and Safety Code plus or minus such amounts as the Commissioner deems necessary as a contingency against unanticipated fluctuations in expenditures and revenues and plus or minus such amounts as the Commissioner deems necessary to correct for over-collections or under-collections in prior years.

(d) The Commissioner may adjust the amount set forth in (b) above as necessary to minimize costs by excluding assessment amounts that are too small to justify the cost of such assessment and collection or if such assessment or collection is impractical.

Authority cited: California Health & Safety Code Sections 127662, California Insurance Code Sections 12921 and 12926.

Reference: California Insurance Code Section 106, California Health and Safety Code Sections 127660, 127661, 127662.

Section 2218.62 Formula for Calculating Fee

(a) The formula for calculating the fee assessed from each health insurer set forth pursuant to 2218.61 shall be based on the number of covered lives insured by a health insurer in the calendar year preceding the first day of the fiscal year in which the assessment is made, calculated by annual statement line of insurance.
(b) The formula for calculating the fee as described in Section 2218.61 is as follows: The aggregate of all covered lives insured by an insurer will be used to determine a percent-to-total ratio for each insurer. This ratio will be multiplied by the total need as defined in Section 2218.60(d) to calculate the amount of the fee to be assessed to each insurer.

Authority cited: California Health & Safety Code Sections 127662 California Insurance Code Sections 12921 and 12926.

Reference: California Insurance Code Section 106, California Health and Safety Code Sections 127660, 127661, 127662~~.~~

Section 2218.63 Issuance of Invoice and Disposition of Assessment Proceeds

(a) The Department of Insurance shall issue an invoice to each health insurer setting forth the amount of the assessment owed. The invoice shall be issued no later than the fifteenth day of June for any assessment.

(b) The invoice described in Section 2218.63(a) shall assess a fee calculated in the manner described in 2218.62 from each health insurer for the Fiscal Years ~~2002-2003, 2003-04, 2004-05 and 2005-06. Separate invoices shall be issued for Fiscal Years 2004-05 and 2005-06, respectively.~~**2006-7, 2007-8, 2008-9 and 2009-10**.

(c) Any amount set forth in the invoice described in 2218.63(a) shall be due and payable upon receipt and shall be considered delinquent if the total amount invoiced is not received within 45 days of the date that the invoice is issued.

(d) Fees assessed and collected pursuant to this section shall be deposited in the Health Care Benefits Fund for the sole purpose of collecting and disbursing funds for the administrative and operational costs arising from the provisions of Chapter 7 (commencing with Section 127660), Part 2 of Division 107 of the Health and Safety Code.

Authority cited: California Health & Safety Code Section 127662
California Insurance Code Sections 12921 and 12926.

Reference: California Insurance Code Section 106, California Health and Safety Code Sections 127660, 127661, 127662,